Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: MCALLEN MEDICAL CENTER 3255 WEST PIONEER PARKWAY ARLINGTON TX 76013	MFDR Tracking #: M4-06-6597-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: AMERICAN HOME ASSURANCE CO Box #: 19	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Knowing that TWCC is hoping to move to a %-over-Medicare allowance for hospital claims, we have reviewed the Medicare DRG allowance and decided your reimbursement does not meet our own determination of fair and reasonable. Medicare would have allowed this facility $7772.59. We are asking the allowable to be 140%-over-Medicare. This would leave an allowable of $10881.63 for this admit."

Amount in Dispute: $9,559.66

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "As a result of the review, no additional payment has been recommended towards the amount in dispute."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Denial Code(s)	Disputed Services	Amount in Dispute	Amount Due
12/1/2005	480, W1, W10, W3, 97, 243, 42, 309, 5036, 5078, 5080, 9999	Inpatient Hospital Services for Trauma Admission	$9,559.66	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on June 7, 2006. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on June 22, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
   - 480-Reimbursement based on the Acute Care Inpatient Hospital Fee Guideline per diem rate allowances.
   - W1-Workers Compensation state fee schedule adjustment.
   - W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - W3-Additional payment made on appeal/reconsideration.
   - 97-Payment is included in the allowance for another service/procedure.

- 243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
- 42-Charges exceed our fee schedule or maximum allowable amount.
- 309-The charge for this procedure exceeds the fee schedule allowance.
- 5036-Complex bill – reviewed by Medical Cost Analysis Team.
- 5078-Supplemental payment.
- 5080-Reimbursed to fair & reasonable.
- 9999-Reconsideration.

2. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC§134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67on the hospital bill finds that the principle diagnosis code is listed as 822.0. The Division therefore determines that this inpatient admission is a trauma admission and shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
3. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Division rule at 28 TAC §133.307(e)(2)(C), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a table listing the specific disputed health care and charges in the form, format and manner prescribed by the commission." Review of the documentation submitted by the requestor finds that the requestor has indicated that the amount billed for the services in dispute is the total for all services charged on the hospital bill; however the documentation does not support that all of the services in dispute were rendered on the date of service listed on the requestor's *Table of Disputed Services*. The requestor listed the disputed date of service as 12/1/2005 on the *Table;* the total charges on the bill were for date of service 11/30/2005, 12/01/2005 and 12/2/2005. The Division concludes that the requestor has failed to complete the required sections of the request in the form, format and manner prescribed under Division rule at 28 TAC §133.307(e)(2)(C).
6. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).
7. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement states that "Knowing that TWCC is hoping to move to a %-over-Medicare allowance for hospital claims, we have reviewed the Medicare DRG allowance and decided your reimbursement does not meet our own determination of fair and reasonable. Medicare would have allowed this facility $7772.59. We are asking the allowable to be 140%-over-Medicare. This would leave an allowable of $10881.63 for this admit."
   - The requestor submitted a copy of a Medicare pricer print-out report to support the position that Medicare would have allowed $7,772.59 for DRG # 219.
   - The requestor does not discuss or explain how payment of 140% over Medicare would result in a fair and reasonable reimbursement.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - The requestor does not discuss or explain how payment of the requested amount would ensure the quality of

medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(e)(2)(C), §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

DECISION/ORDER:

		10/1/2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
		10/1/2010
Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.